EXHIBIT 1

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

PLANNED PARENTHOOD OF THE HEARTLAND, INC., and JILL MEADOWS, M.D., Petitioners, v. TERRY E. BRANSTAD ex rel. STATE OF IOWA and IOWA BOARD OF MEDICINE, Respondents.	Case # AFFIDAVIT OF JILL MEADOWS, M.D.

1. I am the Medical Director of Planned Parenthood of the Heartland (PPH). My duties and responsibilities include providing reproductive health care to patients of Planned Parenthood of the Heartland, including abortion services. I am a board-certified Obstetrician/Gynecologist. Prior to this position, I was an Associate Professor in the Department of Obstetrics and Gynecology at the University of Iowa. Currently, I am an adjunct clinical faculty member and continue to train medical students and residents from the University of Iowa and other institutions. In addition, I have given academic presentations on medical abortion to family medicine and gynecology physicians. My CV is attached hereto as Exhibit A.

2. I submit this affidavit in support of Plaintiffs' Motion for a Temporary Injunction to enjoin enforcement of Section 1 of Senate File 471 ("the Act"), based on my own personal knowledge. I understand that the Act requires our abortion patients to make an extra trip to us; they would have to come to us for an ultrasound (and be given certain state-mandated information), and then wait at least 72 hours after that trip before returning for the procedure. This law will not benefit our patients, as we already perform an ultrasound before providing an

abortion, and screen our patients to ensure they are firm in their decision before we initiate treatment. Moreover, the Act will impose serious burdens on our patients, many of whom already overcome major obstacles to seek the care they need. It will delay patients, thereby exposing them to increased medical risk.

3. Because the Act was given an immediate effective date, these burdens are or will be immediate for the 155 patients we have scheduled between May 1 and May 12, 2017, including 48 patients having a medication abortion via telemedicine. Absent an immediate injunction, these patients will have their abortion appointment abruptly canceled, and have to scramble to schedule an extra visit and delay her abortion. As I explain below, this will mean that patients will be substantially delayed in seeking an abortion, which in turn will expose them to health risks and other burdens, and many patients who were planning to have a medication abortion will suddenly no longer be able to do.

I. PPH and Its Screening Protocols

4. PPH provides a full range of reproductive health care services at 12 health centers in Iowa, including well-women exams, cancer screenings, STI testing and treatment, a range of birth control options including long-acting reversible contraception or LARC, transgender healthcare, and medication and surgical abortion. Medication abortion is the use of a combination of the drugs mifepristone and misoprostol to safely and effectively end an early pregnancy without surgery. It is available in the first 10 weeks of pregnancy, as measured from the first day of the last menstrual period (LMP). Surgical abortion is the use of suction and/or additional instruments to end a pregnancy. In Iowa, we provide surgical and medication abortion

at two clinics, in Des Moines and Iowa City. I understand that a separate provision just passed into Iowa law now prohibits abortions after 21.6 weeks LMP, except in the case of a medical emergency.

5. Six of our other clinics provide medication, but not surgical, abortion. In Ames, we have an in-person physician who provides this care. Since 2008, we also have used telemedicine to provide medication abortion at a number of clinics where we do not have an in-person physician but do have trained staff and the technology needed to allow the physician to remotely screen patients for contraindications. We currently offer medication abortion using telemedicine at 5 health centers, in Burlington, Cedar Falls, Council Bluffs, Bettendorf (Quad Cities), and Sioux City. We also occasionally use telemedicine to ensure continuity of services in Ames, Des Moines, and Iowa City when we are temporarily short-staffed.

6. Over the past year (April 1, 2016 to March 31, 2017), we provided over 2,100 medication abortions and over 1,200 surgical abortions in Iowa.

7. Our mission at PPH is to provide high-quality, patient-centered medical care: that is, "care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."[1] In the context of providing abortions, this means that we are committed to helping each patient make a voluntary, informed, and firm decision about whether to terminate her pregnancy.

8. PPH currently uses a comprehensive informed consent process for abortion, available on the day of the procedure, which provides women with all information necessary for

[1] Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21st Century 3 (Mar. 2001), http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf.

them to fully understand the risks and benefits of abortion and of the alternatives to abortion. PPH also gives its patients multiple opportunities to ask questions and discuss any concerns with their physician prior to an abortion, if that is what she chooses. This process allows a person, after thoroughly considering this information, to give consent that is informed and voluntary.

9. Staff members who take patients through this process are trained to ask open-ended questions, draw out patients about their decision-making and state of mind, and identify red flags that suggest a patient may not be confident in her decision. As part of her medical screening, each patient has an ultrasound. She is asked whether she wants to view the image, and most patients decline.

10. Most patients are already firm in their decision by the time they reach us. In my experience, they have carefully thought through their options and how those options fit, or do not fit, with their values, circumstances, feelings and goals. They often have consulted others. They do not take the decision lightly.

11. Some patients have not reached a firm decision, and we work with them to articulate and consider the values, goals, and circumstances relevant to that decision. And if those do not point *them* to a clear decision, we do not proceed with the abortion and instead advise them to take more time, and we help them identify individuals (such as family members, mentors, or professional counselors) who can support them in their deliberation.

12. As a matter of medical ethics and patient-centered care, it is important that this is an individualized process, tailored to each patient. As providers, we need to respond to each patient's individual preference as long as we can safely do so, whether a patient prefers to be done with the procedure as soon as possible or to take more time with the decision.

II. The Act

13. I am very concerned about the Act, and the effect it will have on our patients.

14. As an initial matter, I am uncertain about what the Act requires. I understand that we must obtain written certification that the patient has been provided with certain information "based upon the materials developed by the department of public health," including "indicators" and "contra-indicators." The Act at 2; Iowa Code § 146A.1(1)(d)(b) (2017). "Indicators" and "contra-indicators" are not medical terms, and I am not sure what they mean. In addition, to my knowledge, the department of public health has not yet developed the materials required by the Act (which is unsurprising since the law was given an immediate effective date).

15. More importantly, I am concerned that the two-trip and mandatory delay requirements of the Act will make it far harder for our patients to access timely care. Many of our patients already struggle to access care for a number of reasons. In general, the earlier an abortion is performed in pregnancy, the safer.

16. For example, many patients have very limited incomes that are already stretched thin; in the last quarter of 2016, for example, over 50% of our abortion patients were at or below 110% of the federal poverty line (meaning, e.g., she made $13,068 or less if single or $17,622 if supporting a child[2]). They are also juggling other commitments: e.g., demanding work-schedules that they cannot predict or control, school, and/or childcare and other family obligations. For similar reasons, it is often hard for their loved ones to arrange to come with them to support them and help them after a procedure. They struggle to find the time and transportation to come for an

[2] Nat'l Conference of State Legislators, *2016 Federal Poverty Level Guidelines* (Jan. 26, 2016), http://www.ncsl.org/research/health/2014-federal-poverty-level-standards.aspx.

appointment, particularly if they are trying to keep their decision confidential. Some people have abusive and/or controlling partners, and face additional difficulties because they must conceal their logistical efforts, and the procedure itself, from that partner. Because of the Act, they now will have to figure out how to make an extra trip or, if they are traveling far, they may need to make arrangements to stay overnight for three nights while they wait for their procedure.

17. I see first-hand how even existing hurdles delay patients in seeking care, and cause them severe stress. I am very worried that the Act's onerous requirements will delay many patients still further, exposing them to unnecessary medical risks associated with later abortion. In general, the earlier in gestation an abortion is performed, the safer the abortion.

18. The Act's mandatory delay will push many of our patients beyond the point in their pregnancy when medication abortion is an option (10 weeks, as measured from the first day of a woman's last menstrual period). Women often are close to that cut-off by the time they reach us—for example, because of the time it took for them to realize they were pregnant, reach a decision to terminate that pregnancy, and/or pull together the time, money, and transportation to seek care. Over the past year, we provided medication abortion to over 600 Iowa women who were in their ninth or tenth week of pregnancy at the time of treatment. Until now, these numbers were on the *rise* because we only recently extended this method to 10 weeks (in February 2017) in response to changes in the medication label and recommendations by the American College of Obstetricians and Gynecologists. Already, in the past few months, we have provided this method to well over 100 patients in their tenth week.

19. Access to medication abortion matters for a number of reasons. First, many of our patients strongly prefer medication abortion over surgical abortion. Many patients prefer the

privacy of having an abortion at home, with loved ones. Many find it easier to fit in with their other obligations, because they can return home from the clinic sooner and control the timing of the process. For some, this method feels more natural and more under their own control. Others are averse to invasive procedures, needles, IV, or sedation. Some of our patients have a history of sexual trauma, and may for that reason be particularly averse to having instruments placed in their vaginas.

20. Some patients have a medical condition that makes medication abortion a safer option. I have had situations where I initiated a surgical procedure but switched to a medication abortion because I discovered that my patient had a condition that made surgical abortion more difficult.

21. Medication abortion is very effective, and only rarely requires surgical follow-up. However, it is most effective earliest in pregnancy, and the risk of needing surgical follow-up (though still low) increases as a patient's pregnancy approaches the 10-week point. Thus, I am concerned that, as a result of delays caused by the Act, more women will need to have surgical follow-up (the very procedure they sought to avoid); many also will need to travel farther for this care, to Des Moines or Iowa City, which will impose additional costs, both for travel and paying for a procedure that is more expensive.

22. Beyond these personal and medical reasons, as I noted above, we have been using telemedicine to offer medication abortion at a number of satellite clinics in rural or outlying areas of the state. When a woman living in one of those areas misses that narrow 10-week window because of the two-trip and mandatory delay requirements in the Act, she will have to travel much farther—in some cases, hundreds of additional miles—to have a surgical abortion in

Des Moines or Iowa City, even if (as I assume) she could have her initial visit at a satellite clinic. For example, just for the procedure itself (leaving aside the initial visit), a woman in Sioux City would have to travel approximately 400 miles round trip. Given the high number of patients we treat who are close to the 10-week cut-off, there is no question that the Act will force some women into this position.

23. I am also concerned about these inevitable delays because I know that delays cause patients severe stress. Whether it is to conceal an unwanted pregnancy from an abusive or controlling partner, or from others who would disapprove or shame her, or to terminate a debilitating pregnancy, or for some other reason, it is important for many patients to be able to end their pregnancy as soon as possible.

24. We also see patients who—because of all the circumstances I described above or because of a fetal anomaly diagnosis or a health condition that developed or worsened as their pregnancy progressed—are close to the point in their pregnancy where we can no longer provide them with an abortion. For example, in the past year, we saw 30 patients at our Des Moines clinic who were within two weeks of the 20-week cut-off there, and 17 patients at our Iowa City health center who were within two-weeks of the 22-week cut-off there. I fear that the Act will prevent these women from being able to have an abortion in Iowa, and may cause some women to carry an unwanted pregnancy to term or to take measures to attempt to self-abort.

25. My fears that the Act will cause significant delay are based not only on my knowledge of my patients' circumstances in Iowa, but also on PPH's experience in Arkansas, where PPH was providing abortions until 2016. In 2015, that state passed a two-trip, 48-hour waiting period (previously, it had required a shorter waiting period and allowed the first

interaction to be over the phone). This change was a disaster for our patients. Our staff was working late into the night (sometimes until 9 p.m.) to fit patients in for an extra visit. Even so, we had to turn away several patients a week. Other patients had to wait a week or longer to complete the process, or travel to a clinic farther away where they could be seen sooner. Additionally, we were forced to charge a higher fee for the procedure to make up costs.

26. The Act will have similar effects in Iowa. Although we will try to fit patients in quickly, just maintaining our current capacity is a big challenge due, in part, to limited clinician availability. In Iowa as elsewhere, individuals involved in abortion care are targeted for harassment or worse; for this reason, it is hard to hire new staff. This challenge is exacerbated by Iowa law, which requires that all abortions, whether surgical or medication, be performed by a physician (even though other advanced practice clinicians can safely provide early abortion, and do so in several other states). Thus, we are only able to schedule abortion patients 1-2 times a week, or even less frequently at some of our outlying clinics. And even without a mandated second visit, we already have to schedule patients out anywhere from one to three weeks or even longer.

27. As a result, patients will be delayed well beyond 72 hours, just on our end (and not taking into account patients' own scheduling constraints). To schedule separate patient visits 72 hours or longer before the abortion procedure, we literally have to double the number of appointments we previously provided for abortion patients. To manage such a drastic expansion of services, practically overnight, we would have to add staff and/or extend staff hours (including for licensed clinicians), among other clinical and operational changes. It will be extremely challenging and unlikely we can find that staff, and even if we can, we cannot sustainably absorb

the additional cost without charging patients more for an abortion. These increased costs will be in addition to increases many patients will face from having to have a later procedure; the cost of an abortion starts at $730 and increases with gestational age.

28. Without increased staffing, we may also be forced to stop providing abortion at some of our health centers. These prospects are painful because I know many of our patients already have such a hard time affording and accessing care, and that these effects, realistically, will substantially delay them or even prevent them altogether from having an abortion.

29. The Act's effects will be particularly painful for the patients we treat who are terminating a wanted pregnancy because of a lethal or severe fetal anomaly such as neural tube defects or chromosomal abnormalities. In many cases, these conditions are not discovered until later in a pregnancy. It is especially cruel to force these people, in the midst of this traumatic experience, to undergo further delay, which in some cases, could even push them past the point where abortion is available in Iowa.

30. The Act also will be especially harmful to people who need to terminate a pregnancy for health reasons that may not fit into the narrow statutory exception because they do not face a risk of death or "a serious risk of substantial and irreversible impairment of a major bodily function." Iowa Code § 146B.1(6). And it will also be particularly harmful to patients who are pregnant as a result of rape and are desperate to end that pregnancy, or who are at risk of abuse if a pregnancy is discovered.

31. Beyond these harms, I strongly object to the Act because it prevents me and other physicians from providing our abortion patients with the medical care they are seeking without imposing requirements which are not imposed on women and men seeking any other type of

medical care. Based on my 20 years of obtaining consent for and providing a wide range of medical care to thousands of patients, I believe there is no medical justification for singling out women seeking abortion care and imposing on them an extreme mandatory delay and two-trip requirement.

32. The Act also intrudes on patient decision-making, reinforces the societal message that women cannot make these decisions responsibly (which is wholly contrary to my experience), and further stigmatizes what is already a highly stigmatized (yet essential) medical option. Women are already bombarded with the message that they should not trust their own judgment and that they are doing something terrible. When they come to our clinic, they often have to walk past protesters shouting these messages at them. Some patients arrive visibly shaken, in tears, from this experience. Singling patients out to receive state-mandated information and then forcing them to wait at least 72 hours before they can return to receive the health care they desire only reinforces that message.

33. For all of these reasons, I believe that the Act will not improve women's decision-making and, instead, will only serve to burden their access to abortion and actually threaten, rather than advance, their health.

Signed this 28 day of April 2017.

Sheri Schnell

NOTARIAL SEAL IOWA
SHERI SCHNELL
COMMISSION NO. 719901
MY COMMISSION EXPIRES
12-10-17

Jill Meadows, MD

EXHIBIT A

JILL LYNELLE MEADOWS, MD
Medical Director
Planned Parenthood of the Heartland
850 Orchard Street
Iowa City, IA 52246

EDUCATION

B.S., Macalester College, St. Paul, MN-1991
M.D., University of Iowa College of Medicine, Iowa City, IA-1995
Resident, Obstetrics and Gynecology, Beth Israel Medical Center, New York, NY-1995-1999

PLANNED PARENTHOOD OF THE HEARTLAND

Medical Director-July, 2010 to present
Abortion Services Director-2010 to present
Early Pregnancy Complications Director-2010 to present
Sedation Program Director-2010 to present
Ultrasound Director-2011 to present
Preceptor for medical students and residents-2010 to present
Laboratory Director-2013 to present
LEEP Program Director-2012 to 2014
Colposcopy Program Director-2013 to 2014
Principle Investigator-Mixed Methods Study of Women's Experiences with Second-Trimester Abortion Care
Principle Investigator-Open-Label Study of a Levonorgestrel-Releasing Intrauterine System for Long-Term Reversible Contraception-2015-present
Principle Investigator-Non-Surgical Alternatives to Treatment of Failed Medical Abortion-2016-present

PROFESSIONAL HISTORY

Academic Positions

Clinical Assistant Professor, University of Iowa Carver College of Medicine, Dept. of OB/Gyn-1999-2005
Clinical Associate Professor, University of Iowa Carver College of Medicine, Dept. of OB/Gyn-2005-2010
Clinical Adjunct Faculty, University of Iowa Carver College of Medicine, Dept. of OB/Gyn-2010 to present

Certification

American Board of Obstetrics and Gynecology-2002

Current Licensure

Iowa-1999
Nebraska-2010
Oklahoma-2016

Professional Affiliations

American Medical Student Association-1991-1995; Chapter President, 1992-1993
American Congress of Obstetricians and Gynecologists, Junior Fellow/Fellow (2002)-1995 to present
Association of Reproductive Health Professionals-2007 to present

Offices

University of Iowa gynecology clinical consultant, Family Practice E-mail Consult Service-1999-2002
University of Iowa departmental Inform Patient Record "super-user"-1999-2004
University of Iowa Gynecology Pre-operative Educational Conference Coordinator-1999-2009

University of Iowa Dept. of OB/Gyn liaison to the Emma Goldman Clinic-1999-2010
Medical Director, Family Planning Council of Iowa Medical Review Committee-2002-2008
Reproductive Health Advisor for the medical student free Mobile Health Clinic-2003-2007
University of Iowa Fibroid Clinic Coordinator (multidisciplinary clinic with Interventional Radiology)-2003-2009
University of Iowa Women's Health Curriculum Task Force-2004
University of Iowa Medical Education Committee-2004-2006
Medical Consultant, Female Breast and Pelvic Exam Program Teaching Video and Simulated Patient Gynecologic Exam Program-2005-2008
University of Iowa Physician Assistant Program Review Committee-2005
University of Iowa First Case Start Improvement Project Committee-2005
Medical Director, University of Iowa Women's Health Clinic-2005-2007
University of Iowa OB/Gyn Resident Education Committee-2005-2007
Faculty Advisor, Medical Students for Choice-2005-2010; awarded Carver College of Medicine Medical Student Government Outstanding Student Organization, 2007-2008
University of Iowa liaison for the Family Practice resident OB/Gyn rotation-2006-2007
University of Iowa Perinatal Illicit Drug Screening Protocol Subcommittee-2006-2007
University of Iowa Protection of Persons Subcommittee-2006-2008
University of Iowa Hospitals and Clinics Quality and Safety Advisory Council-2006-2008
Reviewer, Obstetrics & Gynecology journal-2006-2010
Coordinator, University of Iowa Women's Health Center Procedure Clinic-2009
Medical Director, University of Iowa Ryan Residency Family Planning Training Program-2009
Board of Medical Directors, Physicians for Reproductive Health-2013-present

University of Iowa Service Activities
Private gynecology and obstetric clinics-1999-2010
Teaching of medical students and residents-1999-2010
Staff resident continuity of care clinics-1999-2010
Staff Labor and Delivery-1999-2010
Staff Colposcopy/LEEP Clinic-1999-2010
Staff Ambulatory Surgery Center and Main OR-1999-2010
Staff Emma Goldman Clinic-1999-2010
Staff VAMC gynecology clinic/OR-1999-2009
Medical student shadow/AMWA mentor-1999-2010
Interview prospective medical students-2000-2008
Premedical student shadowing-2000-2008
Staff Fibroid Clinic-2003-2010
Medical student advisor-2005-2010
Medical Student Service Distinction Track Mentor-2007-2009
Staff Procedure Clinic-2009-2010

Publications
"Medication for Medical Abortion", Currents, Vol. 4, #4, pp. 9-10, Fall 2003
"Mixed-methods Study of Women's Experiences with Second-trimester Abortion," Poster, NAF annual meeting, April 2016.
"Mixed-methods Study of Women's Experiences with Second-trimester Abortion," Abstract, North American Forum on Family Planning, Contraception, October 2016.

Grants
University of Iowa New Clinical Initiative Grant for Fibroid Clinic-2005-2007
Ryan Residency Family Planning Training Grant-2009

Awards
The Elliot Blumenthal Award for best resident research project/presentation-1998
The University of Iowa Vagina Warrior Award-2004
Emma Goldman Clinic Golden Speculum Award-2005
The University of Iowa Jean Y. Jew Woman's Rights Award-2005
National Abortion Federation C. Lalor Burdick Award-2013

LECTURES

University of Iowa
Lectures to third-year medical students, "First Trimester Bleeding" (every six weeks)-1999-2001
Lecture to residents and medical students, "Ectopic Pregnancy"-4/25/00
Lecture to residents and medical students, "Evaluation and Treatment of Abnormal Bleeding in Perimenopausal Patient"-5/16/00, 6/16/0
Lecture to residents and medical students, "Chronic Pelvic Pain"-10/31/00
Obstetrics and Gynecology case studies-2000-2009
Lecture to Internal Medicine residents, "Abnormal Uterine Bleeding"-9/28/00, 10/5/00, 1/4/01, 4/5/01
Lectures to 3rd year medical students, "Normal and Abnormal Uterine Bleeding" (every six weeks)-2001-2006
Clinician mentor to 2nd year medical students for Foundations of Clinical Practice-2002-2005
Lecture to residents and medical students, "Induced Abortion"-10/15/02
Lecture to residents and medical students, "Dysmenorrhea"-5/27/03
Lecture to residents and medical students, "Misoprostol in Obstetrics"-11/4/04
Lecture to residents and medical students, "Spontaneous Miscarriage, Evaluation and Treatment"-2/10/04
Faculty Facilitator, Foundations of Clinical Practice Personal and Professional Development-2005-2006
Lecture to 3rd year medical students, "Abortion and Women's Health" (every six weeks)-2006-2010
Lecture to residents and medical students, "Management of Miscarriage"-2/13/07
Lecture to residents and medical students, "Abortion Overview"-7/8/08
Lecture to residents and medical students, "Dysmenorrhea"-10/21/08
Clinical Skills Workshop for third year medical students using papayas (every six weeks)-2009; for residents 1/13/09 and 6/09
Lecture to residents and medical students, "Induced Abortion"-7/8/08
Lecture to second year medical students (FCP). "Spontaneous and Induced Abortion Overview"-11/7/08
Lecture to reproductive epidemiology students, "Fibroids" and "Spontaneous and Induced Abortion Overview"-12/4/08
Lecture to residents and medical students, "Ryan Program Overview"-1/13/09
Lecture to residents and medical students, "Mifepristone/Misoprostol for Second Trimester Medical Abortion"-2/16/09
Lecture to residents and medical students, "DMPA for Contraception"-3/10/09
Lecture to residents and medical students, "First Trimester Medical Abortion"-6/9/09
Lecture to residents and medical students, "OCPs-The Basics"-8/11/09
Lecture to residents and medical students, "Primary Reproductive Health and the Law"-10/13/09
Journal Club with residents and medical students: "Rates of Serious Infection after Changes in Regimens for Medical Abortion," NEJM-12/09

Planned Parenthood of the Heartland
Reversal Agents for Moderate Sedation-11/1/10
Sedation Basics Review-5/4/12
BHCG Review webinar-10/15/12
Miscarriage Management webinar-1/14/13
Delayed Post Abortion Complications webinar-3/11/13
Delayed Post Abortion Complications presentation, clinician meeting-9/9/14

2015 Medical Standards & Guidelines Abortion Update/Sedation webinar-2/15
Presentation on Abortion Services to PPHeartland Board-1/16
Delayed Post Abortion Complications presentation, clinician meeting-9/20/16

Invited Lectures

"Evaluation and Treatment of Abnormal Bleeding in The Perimenopausal Patient," Visiting Professor lecture, Broadlawns, Des Moines, IA-5/7/01
"RU-486 Update," Conference presentation, University of Iowa Family Practice refresher course, Iowa City, IA-4/6/01
"RU-486 Update," OB/Gyn Postgraduate Conference, Iowa City, IA-9/22/01
"Elective Induction of Labor," University of Iowa OB/Gyn Grand Rounds-5/22/02
"Ectopic Pregnancies," Visiting Professor lecture, Mason City, IA-10/13/04
"Misoprostol in Obstetrics," Visiting Professor lecture, Mason City, IA-10/13/04
"Abnormal Bleeding in the Perimenopausal Patient," Spring Nurse Conference, University of Iowa College of Nursing, Iowa City, IA-4/7/05
"Complications of Abortion, Current Controversies," University of Iowa OB/Gyn Grand Rounds-5/25/05
"Symptomatic Fibroid Treatment," Women's Health Conference, University of Iowa Dept. of Nursing Services and Patient Care-10/12/05
"This is God's Work," Panel participant, NAF Annual Conference, San Francisco, CA-4/25/06
"First Trimester Bleeding," Visiting Professor lecture, Davenport, IA-4/29/06
"Management of Spontaneous Abortion," Visiting Professor lecture, Davenport, IA-4/29/06
Periodic presentations to local AMWA and MSFC chapters-2000-2009
"Abnormal Uterine Bleeding," Iowa Nurse Practitioner Society Annual Conference, Des Moines, IA-10/19/07
"Management of Early Pregnancy Loss;" "Medication Abortion," Options for Early Pregnancy Loss or Therapeutic Abortion Workshop, Iowa City, IA-9/12/08
"Dysmenorrhea Treatment," Iowa Pharmacists CME, Iowa City, IA-9/16/08
"Carhart vs. Gonzalez: A Plaintiff's Perspective," Des Moines University-12/4/08
"Essure Hysteroscopic Tubal Occlusion: Sterilization and Beyond," University of Iowa OB/Gyn Grand Rounds-4/14/09
Implanon Training Session, Cedar Rapids, IA-4/21/09
"Induced Abortion," Reproductive Health Elective, Des Moines University-2/15/11
"Medical Students for Choice-Finding Your Voice," MSFC Regional Conference, Minneapolis, MN-3/24/12
Nebraska roundtable discussion on family planning education, sponsored by the Urban Institute-University of Nebraska Medical Center, 9/13

COMMUNITY SERVICE

Emma Goldman Clinic GBLT annual free clinic volunteer staff-2000-2008
Iowa City Area NOW Chapter President-2002-2005
Reproductive Health free mobile medical clinic volunteer staff, Broadway Neighborhood Center-2003-2006
Riverside Theatre actor housing host-2004-2005
Iowans Marching for Women's Lives Coalition Chair-2006
Church worship committee chair-2008
Iowa Abortion Access Fund board member-2008-2010; Development Committee-2008; Vice President and Policies & Procedures Committee Chair-2009; President-2010
Children's Moment church leader-2010-2016
First Christian Church Mission and Witness committee member-2012-2016; Chair-2014-2016
Coralville Ecumenical Food Pantry volunteer-2013-2015
First Christian Church Deacon/board member-2014-2017